

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-023160

STATE FILE NUMBER

Registration District No. 032 Primary Registration District No. 4564 Registrar's No. 43

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0090

2 0090

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

8-23-63

10-10-1889

10-10-1881

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FILED JUL 5 1963

1. PLACE OF DEATH a. COUNTY Bollinger		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Bollinger	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN zalma		Length of stay in 1b life	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION residence		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Mae Last Slinkard		4. DATE OF DEATH Month June Day 6 Year 1963	
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-10-1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11a. FATHER'S NAME Rev. Jacob Eaker		11b. MOTHER'S MAIDEN NAME Martha Jane Day	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates) no		13. SOCIAL SECURITY NO. none	
14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH ?	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		PART III. If deceased was female was there a pregnancy in last 90 days: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
20c. TIME OF INJURY. Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from 2-12-59 to 1-9-63 and last saw her			

AUG 23 1963

JUL 5 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

W. H. Morgan

Licensed Embalmer No. 4640

P. O. Address Advance, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.